Vaccine Consent Form

Haworth Apothecary
169 Terrace Street, Haworth, NJ 07641
201-384-7171

HAWORTH APOTHECARY
WELLNESS CENTER & GIFT SHOP

Patient Information

Form 1 of 2 to be completed

Last Name | First Name | Date of Birth | Gender

Address | City | State | Zip | County

Cell Phone # | Home Phone # | Email Address

Please check off the corresponding boxes of the vaccine you would like to receive

- ◯ **RSV**
- ◯ **Covid Booster**
- ◯ **Influenza**
- ◯ **Shingles**
- ◯ **Pneumonia**
- ◯ **Other:**_____

Scan QR code for more information on Influenza vaccine. If you cannot scan, please see pharmacy for more information

Insurance Information

Prescription Insurance: ◯ Yes ◯ No

Are you the Primary Cardholder? | If No, include the Primary Cardholder's DOB

Prescription Benefit Plan Name | Cardholder ID# | RX Group ID | PCN | BIN

Medicare Fields:

◯ Yes ◯ No

Is the Patient age 65 or older or Medicare Eligible?
Refer to your Medicare Red, White, and Blue card

Medicare Part A/B ID Number (MBI)
Note: MBI is required for all patients age 65 and older, or Medicare eligible.

Haworth Apothecary will send vaccination information upon request from this visit to your doctor/primary care provider using the contact information provided below.

Doctor/Primary care provider name:_____ Fax Number:_____

Immunization Screening Questions	YES	No	Don't Know
1. Are you sick today? Have you had a new onset of fever, chills, cough, shorthess of breath, fatigue difficulty breathing, muscle or body aches, headahce, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	◯	◯	◯
2. Do you have allergies or reactions to any foods, medications, vaccines or latex?	◯	◯	◯
3. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	◯	◯	◯
4. In the past two weeks, have you tested positive and/or have been in contact with anyone who tested positive for COVID-19?	◯	◯	◯
5. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	◯	◯	◯
6. Do you take anticoagulation medication? For example: Warfarin, Coumadin or other blood thinner	◯	◯	◯
7. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?	◯	◯	◯
8. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem?	◯	◯	◯
9. Do you have a weakened immune system or in past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments?	◯	◯	◯
10. During the past year, have you received a transfusion of blood or blood products, or been give immune (gamma) globulin or an antiviral drug?	◯	◯	◯
11. For women, are you pregnant or is there a chance you could become pregnant during the next month?	◯	◯	◯
12. Have you received any vaccinations or TB skin test in the past 4 weeks?	◯	◯	◯

Form 2 of 2 to be completed

Last Name:_____ First Name:_____ **DOB:**_____

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Terrace Apothecary dba Haworth Apothecary to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that Terrace Apothecary dba Haworth Apothecary may be required to or may voluntarily disclose my health information to the physician responsible (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment, or other health care operations (such as administration or quality assurance). I also understand that Terrace Apothecary dba Haworth Apothecary will use and disclose my health information as set forth in the Notice of Privacy Practices (copy is available in-store or by requesting a paper copy from the pharmacy).

X

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) **Date**

If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Name of parent, guardian, or authorized representative | Relationship | Phone Number

As required for state immunization registry reporting.

Race: 1 - American Indian or Alaska Native, Tribe:_____ 2 - Asian 3 - Black or African American
4 - Native Hawaiian or Other Pacific Islander 5 - White 6 - Other Race
7 - Prefer not to specify

Ethnicity: 1 - Hispanic 2 - Not Hispanic or Latino 3 - Unknown 4 - Prefer not to specify

Language Spoken: **Birth Country:** **Plurality:**

Vaccine Administration Information for Immunizer/Pharmacist use only

1

Administration Date	Vaccine		VIS Date	Manufacturer
		IM		◯ L ◯ R
Lot#	**Exp. Date**	**Route**		**Site** **Volume (mL)**

2

Administration Date	Vaccine		VIS Date	Manufacturer
		IM		◯ L ◯ R